STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445075	A. BUILDING _____ B. WING _____	08/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTHCARE	431 LARKIN SPRING RD MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigation # TN00028191, #28136, #28259, and #28465 were completed during the annual Recertification survey on August 8-10, 2011, at Madison Healthcare. Complaint #28259 was substantiated with deficiencies cited in relation to the complaint under 42 CFR Part 482.13, Requirements for Long Term Care.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	F157 It is the practice of this facility to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse treat); or a decision to transfer or discharge the resident from the facility as specified in 4832.12(a). Resident #19 was discharged on 7/1/2011 to be closer to his family. Licensed nurses and nursing supervisors will be re-educated by the Staff Development Coordinator no later than Sept 16, 2011 regarding notifying physician and / or nurse practitioner of facility policy regarding "Resident Exhibiting Challenging Behaviors" see attached exhibit F157 A and "Notification" see attached exhibit F157 B. The DON, ADON, nursing supervisors will review the twenty four hour report, physician orders,	9-16-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Phyllis Cheney Executive Director | August 22, 2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to notify the physician of a change in behavior for one resident (# 19) of twenty-one residents reviewed. The findings included: Resident #19 was admitted to the facility on April 7, 2010, with diagnoses including Hypertension, Diabetes Mellitus, and Peripheral Vascular Disease. Medical record review of a nurse's note dated May 7, 2011, revealed, "...discovered an oral thermometer probe cover inserted into...penis...box of probe covers discovered at bedside..." Medical record review of the facility policy for "Resident Exhibiting Challenging Behaviors revealed, "...notification of physician of behavior symptoms..." Interview with the Assistant Director of Nursing (ADON) in the Director of Nursing office on August 10, 2011, at 2:30 p.m., verified the self-inflicted behavior was a change for resident #19; and confirmed the facility failed to notify the physician of a change in behavior.	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F157 Continued and medical records during the morning Clinical Meeting to ensure proper notification of changes (injury/decline/room, etc). The DON, ADON, Nursing Supervisors will complete the "Review of Process Measures – Notifying Family, Physician, and Resident Change of Condition" see attachment F157 C monthly for 3 months or until no further discrepancies are noted, on 10 residents to ensure compliance of notification. The DON will report audit findings along with any corrective and / or disciplinary actions to the facility performance improvement committee (Executive Director, DNS, Plant Operations Mgr, Dietary Manager, ADON, Staff Development Coordinator, Activity Director, Social Service Director, Housekeeping / Laundry Supervisor, and Medical Director) at its monthly meeting for review and recommendations as identified and needed.	9-16-11

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F 157	Continued From page 2 complaint # 28259	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to timely obtain mental health services after a self-inflicted behavior had developed for one resident (# 19), of twenty-one residents reviewed. The findings included: Resident #19 was admitted to the facility on April 7, 2010, with diagnoses including Hypertension, Diabetes Mellitus, and Peripheral Vascular Disease. Medical record review of a nurse's note dated May 7, 2011, revealed, "...discovered an oral thermometer probe cover inserted into...penis...box of probe covers discovered at bedside..." Medical record review of the Nurse Practitioner's note dated June 8, 2011 revealed "Staff request consult d/t (due to) recent incident 6/6/11 in which tech (technician) caught resident sticking thermometer inside his urethra, which has	F 250	F 250 It is the practice of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Resident # 19 was discharged 7/01/2011 to another facility closer to his family. Members of the Interdisciplinary Team (MDS Coordinator, Social Service Director, DON, and ADON) will review all residents coded 1, 2, or 3, in MDS section EO200 Behavioral Symptom – Presence and Frequency and all orders coded "PY" (indicating an order for psyche services has been received) to ensure services have been rendered timely no later than 9/16/2011. The Medical Records Clerk will bring phone orders to the Clinical Morning Meeting for review by DNS, ADNS, and Nursing Supervisors to ensure physician orders are carried out timely. The DON, ADON, Nursing Supervisors, Social Service Director will review monthly 10% of residents records coded "PY" to ensure service are rendered timely monthly for three months or until no discrepancies are noted. The Social Service Director will report audit findings along with any corrective actions to the facility Performance Improvement Committee (Executive Director, DNS, Plant	9-16-11

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F 250	Continued From page 3 happened on a previous occasion. Patient has also had prior incidents of inappropriate sexual remarks toward staff and fondling other residents, though specific incidents are not charted." Medical record review revealed a physician's telephone order, dated June 9, 2011 stating, "Refer to psychologist for counseling r/t (related to) inappropriate sexual behaviors." Medical record review of the facility policy # PRO 51005 for "Resident Exhibiting Challenging Behaviors" revealed, "8. Notifify mental health professional..." Interview with the Social Services Director on August 10, 2011, at 1:30 p.m., in the dining area, confirmed the facility delayed in obtaining mental health services for the resident.	F 250	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F250 Continued Operations Mgr, Dietary Manager, ADON, Staff Development Coordinator, Activity Director, Social Service Director, Housekeeping/Laundry Supervisor, and Medical Director) at its monthly meeting for review and recommendations as indentified and needed monthly for three months or until no further discrepancies are noted.	9-16-11
F 279 SS=D	complaint # 28259 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279	See page 5 of 18 for (Copy) F279	

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F 250	Continued From page 3 happened on a previous occasion. Patient has also had prior incidents of inappropriate sexual remarks toward staff and fondling other residents, though specific incidents are not charted." Medical record review revealed a physician's telephone order, dated June 9, 2011 stating, "Refer to psychologist for counseling r/t (related to) inappropriate sexual behaviors." Medical record review of the facility policy # PRO 51005 for "Resident Exhibiting Challenging Behaviors" revealed, "8. Notifify mental health professional..." Interview with the Social Services Director on August 10, 2011, at 1:30 p.m., in the dining area, confirmed the facility delayed in obtaining mental health services for the resident.	F 250	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 279 It is the practice of this facility for the results of the assessment to develop, review and revise the residents comprehensive plan of care. Resident #19 was discharged on July 1, 2011 to be closer to his family. Members of the Interdisciplinary Team (MDS Coordinator, Social Service director, DON, and ADON) will review all residents coded 1, 2, or 3 in MDS section EO200 Behavioral Symptom – Presence and Frequency and all order coded "PY" (indicating an order for psyche services has been received) to ensure plan of care has been updated to reflect a change in behavior or condition no later than September 15, 2011. The Medical Records Clerk will bring phone orders and medical records of residents with phone orders or change of condition noted on the twenty four hour to the Clinical Morning Meeting for review by DNS, ADNS, and Nursing Supervisor to ensure the residents Plan of Care has been updated to reflect changes in behavior. The DON, ADON, Nursing Supervisors, Social Service Director, and MDS Coordinator will review monthly 10% of resident records coded "PY" using the "Review of Process Measures – Monitoring Behaviors" PI tool (see attached exhibit F279A) to ensure the plan of care has been	9-16-11
F 279 SS=D	complaint # 28259 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		

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F 279	Continued From page 4 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review and interview, the facility failed to update the care plan to reflect a change in behavior for one resident (#19) of twenty-one residents reviewed. The findings included: Resident #19 was admitted to the facility on April 7, 2010, with diagnoses including Hypertension, Diabetes Mellitus, and Peripheral Vascular Disease. Medical record review of a nurse's note dated May 7, 2011, revealed, "...discovered an oral thermometer probe cover inserted into...penis...box of probe covers discovered at bedside..." Medical record review of the facility policy for "Resident Exhibiting Challenging Behaviors" revealed, "...update care plan..." Interview and medical record review with the Assistant Director of Nursing (ADON) in the conference room on August 10, 2011, at 5:05 p.m., confirmed the care plan had not been	F 279	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F279 Continued updated to reflect change in behavior or condition monthly for 3 months or until no further discrepancies are noted. The Social Service Director will report audit findings along with any corrective actions to the facility Performance Improvement Committee (Executive Director, DNS, Plant Operations Mgr, Dietary Manager, ADON, Staff Development Coordinator, Activity Director, Social Service director, Housekeeping / Laundry Supervisor, and Medical Director) at its monthly meeting for three months or until no further discrepancies are noted for review and recommendations as identified and needed.	9-16-11

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F 279	Continued From page 5 updated to reflect the change in behavior. complaint # 28259	F 279	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to obtain oxygen saturations as ordered by the physician for one (#16) and the facility failed to ensure medications were secure for one resident (#12) of twenty-one residents reviewed. The findings included: Resident #16 was admitted to the facility on July 20, 2011, with diagnoses including Tracheostomy, Cancer of the Larynx, Laryngectomy, Chronic Obstructive Pulmonary Disease, and history of Myocardial Infarction. Medical record review of the Physician's Orders for Respiratory /Pulmonary Care (undated but with the admission orders dated July 20, 2011) revealed an order for "Monitor O2 sat (Oxygen saturation) /pulse oximetry Q (every) shift." Interview with the Director of Nursing (DON) in the conference room on August 8, 2011, at 1:15 p.m., revealed the nurses work 8 hour shifts (three shifts per 24 hours). Medical record review revealed no documentation of a recorded oxygen	F 281	F281 It is the practice of this facility to provide and arranges services that meet professional standards of quality. The procedure for documenting the oxygen saturations for Resident #16 was changed August 10, 2011 to be recorded on the Medication Administration Record in place of the Vital Sign Sheet. August 10, 2011 licensed staff caring for Resident #16 were re-educated by the DON on proper documentation of oxygen saturations and following physician orders. The Staff Development Coordinator will re-educate licensed nursing staff by 9/16/2011 regarding following "Physician's Orders For Respiratory/Pulmonary Care" and proper documentation. The Medical Records Clerk will audit 10% of the medical records for residents with orders to obtain oxygen saturations monthly for three months or until no further discrepancies are noted to ensure compliance. Discrepancies will be reported immediately to the DNS. August 9, 2011 Licensed nurse #2 discussed with Director of Nursing her error in leaving medications on the resident's over bed table and walking into the bathroom. Director of Nurses re-educated Licensed nurse #2 regarding proper medication administration and expectations of compliance. The Staff Development Coordinator will re-educate	9-16-11

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F 281	Continued From page 6 saturation level after July 29, 2011. Observation on August 9, 2011, at 3:45 p.m., revealed the resident in the room receiving physical therapy while sitting upright in a gerichair. Observation revealed the resident was receiving humidified oxygen at 35% by trach collar; and had a Tracheostomy tube secured by a neck collar via Velcro straps. Medical record review and interview with the Director of Nursing in the DON's office on August 10, 2011, at 9:15 a.m., confirmed the facility failed to obtain and document an oxygen saturation level from July 29 until August 10, 2011; a period of 11 days. Resident #12 was admitted to the facility on January 19, 2011, with diagnoses including Muscle Weakness, History of Falls, and Diabetes Mellitus, and Altered Mental Status. Observation on August 9, 2011, at 8:35 a.m., in the resident's room, revealed Licensed Practical Nurse (LPN) #2 crushed a multivitamin and a B-1 vitamin, placed the medications into separate plastic soufflé cups, and walked into the resident's room to administer the medications. Continued observation revealed LPN # 2 placed the plastic soufflé cups on the resident's over bed table, walked into the resident's bathroom and then walked outside the resident's room down the hallway to wash the hands, leaving the medications out of the eyesight of the LPN.	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F281 Continued licensed nursing staff no later than 9/16/2011 on policy and procedure of "Medication Administration" PRO 62002. See attached exhibit F281 A. The Staff Development Coordinator will complete the "Medication Pass Observation Review" (see attached exhibit F281 C) on all newly hired licensed nurses within 90 days and all other licensed nurses every six months. The Staff Development Coordinator will report audit findings along with any corrective actions to the facility Performance Improvement Committee (Executive Director, DNS, Plant Operations Mgr, Dietary Manager, ADON, Staff Development Coordinator, Activity Director, Social Service Director, Housekeeping /Laundry supervisor, and Medical Director) at the its monthly meeting for three months or until no further discrepancies are noted for review and recommendations as identified and needed.	9-16-11

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F 281	Continued From page 7 Interview with LPN #2 outside the resident's room, on August 9, 2011 at 8:42 a.m., confirmed the LPN left the medications at the bedside and exited the room, leaving the medications unsupervised.	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review and interview, the facility failed to ensure staff raised the head of bed for prevention of aspiration for one (#12) resident receiving a tube feeding, of twenty-one residents reviewed. The findings included: Resident #12 was admitted to the facility on January 19, 2011, with diagnoses including Muscle Weakness, History of Falls, and Diabetes Mellitus and Altered Mental Status. Medical record review of a Physician's Order for Enteral Nutrition dated August 5, 2011, revealed "...(named enteral feeding product) at 120 ml (milliliters) q (every) four hours via bolus per NG	F 322	F 322 It is the practice of this facility to ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. August 9, 2011 LPN #2 administering the enteral feeding to Resident #12 reported to Director of Nursing that she failed to elevate the HOB 30-45 degrees. The Director of Nursing re-educated the nurse on proper administration of medication via feeding tube and enteral feedings. The Staff Development Coordinator will re-educate licensed staff no later than 9/15/2011 regarding policy and procedures "Enteral Feeding: Pump Method" PRO 66001-02 (see exhibit F 322 A) and "Enteral Feeding: Gravity Method" PRO 6001-01 (see attached exhibit F322 B). The Staff Development Coordinator will complete competency skills check for proper administration of enteral feedings on licensed staff no less than annually. The Staff Development Coordinator will complete the "Monitoring Enteral Feeding Administration" audit tool monthly for three months or until no further discrepancies are	9-16-11

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F 322	Continued From page 8 (nasogastic) tube". Review of the physician's orders revealed, "Elevate HOB (head of bed) to 30-45 degrees at all times during feeding and for at least 30-45 minutes after the feeding is stopped." Review of the facility's "Enteral Feeding Administration" policy revealed, "...Elevate the head of the bed 30-45 degree angle during feeding..." Observation on August 9, 2011, at 8:35 a.m., in the resident room, revealed resident #12 lying flat in bed. Continued observation revealed Licensed Practical Nurse (LPN #2) administered the enteral feeding to the resident via the nasogastric tube (tube from nose to stomach). Observation revealed, LPN #2 placed a 60 ml syringe into the NG tube and administered the complete volume of enteral feeding fluid into the NG tube. Continued observation revealed the LPN failed to elevate the head of the bed 30-45 degrees. Interview with LPN #2 outside the resident's room, on August 9, 2011 at 8:42 a.m., confirmed the HOB was not elevated during the tube feeding and not for 30-45 minutes after the feeding for the prevention of aspiration.	F 322	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F322 Continued noted on all residents who are fed by a naso-gastric or gastrostomy tube. The SDC will immediately address any discrepancies and report to DNS. The DNS, ADON, SDC, and Nursing Supervisors will do daily rounds to ensure the HOB of tube fed residents is elevated. The SDC will report audit findings along with any corrective actions to the facility Performance Improvement Committee (Executive Director, DNS, Plant Operations Mgr, Dietary Manager, ADON, Staff Development Coordinator, Activity Director, Social Service Director, Housekeeping /Laundry supervisor, and Medical Director) at its monthly meeting for three months or until no further discrepancies are noted for review and recommendations as identified and needed.	9-16-11
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	See page 10 of 18 for F323	

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	445075	A. BUILDING _____ B. WING _____	08/10/2011

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F 323	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation, observation, and interview, the facility failed to ensure a safety device was in place for one (#14) of twenty-one residents reviewed. The findings included: Resident #14 was admitted to the facility on March 7, 2011, with History of Osteoporosis, Congestive Heart Failure, Diabetes Mellitus, L1-L2 Fracture with Vertebroplasty, and Dementia. Medical record review of the Minimum Data Set dated June 6, 2011, revealed the resident had severe cognitive impairment; required extensive assistance with one person physical assist for mobility, transferring, ambulating in the room, dressing, toileting, personal hygiene and bathing. Further review revealed the resident had experienced a fall both with and without injury. Medical record review of the Admission Nursing Assessment dated March 7, 2011, revealed the resident was at high risk for falls. Medical record review and review of a facility investigation, revealed the resident fell on April 12, 2011, resulting in a skin tear; was discharge from physical therapy; and was referred to restorative nursing care.	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 323 It is the practice of this facility to ensure that the residents environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. August 10, 2011 Resident # 14 was re-assessed by the Director of Nursing for further need of a personal tab alarm on resident when in bed. It was determined that the resident no longer needed the alarm while in bed. The care plan and C.N.T. care plan was updated to reflect change. Resident #14 was placed on the "Falling Star Program". The Nursing Supervisors will monitor residents with assistance devices to prevent accidents to ensure the devices in place as ordered during daily rounds monthly for three months until no further discrepancies are noted. They will immediately address any discrepancies and report to the DON. The Interdisciplinary Care Plan Team (DON, MDS Coordinators, Activity Director, Registered Dietitian, Social Service Director) meet weekly to review and update residents on the Falling Star Program to ensure their plan of care interventions, supervision and assistance devices are maintaining an environment that is as free of accident hazards as possible.	9-16-11

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F 323	Continued From page 10 Medical record review revealed on April 27, 2011, the resident was found on the floor in front of the wheelchair, with a complaint of right hip pain. Further review revealed the immediate intervention was to add a personal tab alarm when in bed and wheelchair. Review of the x-ray dated April 27, 2011, revealed "...chronic healed proximal right femur fracture status post ORIF, no acute osseous abnormality, osteoarthritis..." Medical record review of the care plan initiated on March 18, 2011, revealed a problem of "a...history of falls with hip fracture, cognitive deficits, decreased physical mobility r/t (related to)...balance/gait are unsteady...attempt to transfer and ambulate unassisted..." Further review revealed an approach added on May 12, 2011,"...personal tab alarm on...bed and...wheelchair..." Observation on August 10, 2011, at 8:30 a.m., revealed the resident in bed eating breakfast. Further observation revealed no alarm was present and no alarm was attached to the resident in the bed. Interview with Certified Nurse Aide (CNA) #1 on August 10, 2011 at 10:00 a.m., in the resident's room, revealed the CNA had transferred the resident from the bed to the wheelchair this morning. Further interview confirmed the resident did not have an alarm on the bed or attached to the resident when the resident was in the bed prior to the transfer. Interview with the Licensed Practical Nurse Case	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 323 continued The plan of care and C.N.T. plan of care is updated by MDS Coordinator to reflect any changes. The DON, ADON, and Nursing Supervisors will monitor compliance of following care plan interventions for providing an environment that remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents during daily rounds. The DON will report any findings of non-compliance along with any corrective actions to the facility Performance Improvement Committee (Executive Director, DNS, Plant Operations Mgr, Dietary Manager, ADON, Staff Development Coordinator, Activity Director, Social Service Director, Housekeeping /Laundry supervisor, and Medical Director) at its monthly meeting for three months or until no further discrepancies are noted.	9-16-11

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F 323	Continued From page 11 Manager on August 10, 2011 at 10:48 a.m., in the conference room, confirmed the resident was care-planned to have a personal tab alarm when in bed and while in the wheelchair. Continued interview confirmed the facility failed to ensure the safety device was in place.	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to ensure staff performed sterile tracheal suctioning for one (#16) of twenty-one residents reviewed. The findings included: Resident #16 was admitted to the facility on July 20, 2011, with diagnoses including Tracheostomy, Cancer of the Larynx, Laryngectomy, Chronic Obstructive Pulmonary Disease, and history of Myocardial Infarction.	F 328	F 328 It is the practice of this facility to ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. The Licensed Practical Nurse #1 for Resident #16 was suspended August 9, 2011 pending investigation for not following facility policy PRO 66309 titled Tracheostomy Care. August 15, 2011, prior to Licensed Nurse #1 resuming job duties and rendering resident care, the ADON re-educated her on the facility policy "Tracheostomy Care" and performed a return demonstration and skills check off for "Endotracheal Care". See attached exhibit F328 A and F328 B. The Staff Development Coordinator will complete the skills competency check off for "Endotracheal Care" on newly hired licensed staff within 90 days and current staff no less than annually. The Staff Development Coordinator will randomly observe 3 nurses, utilizing the skill competency check off sheet for Endotracheal Care, monthly for three months or until no further discrepancies or deficient practices are noted to ensure compliance of policy and	9-16-11

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F 328	Continued From page 12 Observation on August 9, 2011, at 3:45 p.m., revealed the resident sitting upright in a gerichair. Observation revealed the resident was receiving humidified oxygen at 35% by trach collar; and had a Tracheostomy with a Tracheal tube secured by a neck collar via Velcro straps. Observation revealed the resident moved head from left to right and mouthed "no" when asked "are you okay?" The resident's cough indicated secretions were loose. Observation revealed Licensed Practical Nurse (LPN #1) was in the room and stated, "I will suction (the resident)." The LPN #1 donned unsterile gloves and picked up the Yankauer (suction device used to remove mucus from the mouth) which was attached to the resident's gown, and inserted the Yankauer into the tracheal tube until resistance was met ("3/4 of an inch"); and applied suction to remove a small amount of secretions. Observation revealed the LPN #1 put the Yankauer in a cup of water to clear the secretions, and replaced the Yankauer on the resident's gown. Interview with LPN #1 outside the resident's room on August 9, 2011, at 4:12 p.m., revealed the resident independently used the Yankauer to remove the secretions from the oral cavity. Review of the facility policy number PRO 66309 titled Tracheostomy Care, revealed a sterile suction catheter kit (containing sterile gloves, sterile water, and sterile catheter) was required for suctioning, and the procedure was to be performed in a sterile manner. Interview with the Director of Nursing (DON) in	F 328	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 328 Continued procedures. The Staff Development Coordinator will immediately address any deficient practice and report to DON. The Staff Development Coordinator will report audit findings along with any corrective actions to the facility Performance Improvement Committee (Executive Director, DNS, Plant Operations Mgr, Dietary Manager, ADON, Staff Development Coordinator, Activity Director, Social Service Director, Housekeeping /Laundry supervisor, and Medical Director) at its monthly meeting for three months, or until no further discrepancies or deficient practices are noted, for review and recommendations as identified and needed.	9-16-11

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F 328	Continued From page 13 the DON's office on August 9, 2011, at 5:10 p.m., verified the Yankauer suction was to be used for oral secretions (not for tracheal suctioning), and confirmed the facility policy was for the LPN to use a sterile suction catheter that would fit into the tracheal tube to allow for appropriate, deeper suctioning.	F 328	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of chemical sanitizer recommendation for the three compartment sink, and interview, the facility dietary department failed to sanitize pots, pans and utensils per the manufacturer's recommendations and failed to maintain sanitary dietary equipment. The findings included: Observation on August 8, 2011, beginning at 10:50 a.m., with the Registered Dietitian present, revealed the following: 1. The three compartment sink was in operation. Further observation revealed cooking and portion	F 371	F 371: It is the practice of this facility to 1)Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and 2) Store, prepare, distribute and serve food under sanitary conditions. August 8, 2011 Echo Lab was immediately notified and made a service call to check the sanitizer dispensing machine and correct problem for machine to dispense appropriate amount of liquid. Representative instructed the Dietary Manger and Registered Dietician on proper dispensing method. The Dietary Manager and RD immediately re-educated staff on the proper dispensing method as directed by Echo Lab. 8/09/2011 the spill pan and back splash on the stove were cleaned by the Cook. 8/19/2010 the RD and DM held a dietary staff meeting to re-educate the staff regarding cleaning schedule and proper dispensing of sanitizer and accountability to follow schedule and dispensing method. Failure for staff to follow procedure for serving food under sanitary conditions will lead to disciplinary actions up to and including termination. The DM and RD updated the daily cleaning schedule to include specific task and person responsible. (See addendum 371 / A) The Cook will be	9-16-11

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F 371	Continued From page 14 control serving utensils in the sanitizer sink and dietary items on the drain board. Further observation revealed the dietary staff member checking the sanitizer level. Further observation revealed the quaternary test strip did not change colors (indicating insufficient level of sanitizer). 2. The four burner range top, spill pan, and back splash had a heavy accumulation of sticky, blackened debris. Observation on August 9, 2011, at 7:48 a.m., with the Registered Dietitian, confirmed the range top, spill pan and back splash had a heavy accumulation of sticky, blackened debris. Review of the three compartment sink poster for sanitizer level recommendation revealed the quaternary chemical sanitizer level was 150 to 400 parts per million. Interview, with the Registered Dietitian in the dietary department on August 8, 2011 at 10:50 a.m., and on August 9, 2011, at 7:48 a.m., confirmed the quaternary test strip did not change color indicating the sanitizer level was less than 150 parts per million for sanitizing equipment. Further interview confirmed the facility failed to maintain the dietary department/equipment in a sanitary manner.	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F371 Continued responsible for cleaning the spill pan, back splash, and stove at the end of their shift. The Cook will be responsible for checking the "Sanitizer Log" each shift. (See addendum 371/ B) The DM will be responsible for utilizing the PI Nutrition Services: "Quick Rounds" tool five (5) days a week for one month or until substantial compliance has been achieved and determine adherence to policy and procedures then 3-5 days a week thereafter. The RD will make weekly rounds with the DM utilizing the Nutrition Services: "Quick Rounds" PI tool weekly. The ED will complete the PI Nutrition Services "Quick Round" tool every two weeks with the RD and DM until 95% compliance is maintained for one month then monthly and randomly thereafter. The RD will report the results of these PI tools, along with any corrective and/ or disciplinary action to the facility performance improvement committee (Executive Director, DNS, Plant Operations Mgr, DM Mgr, ADON, Staff Development Coordinator, Activity Director, Social Service Director, Housekeeping/Laundry Supervisor, and Medical Director) at its monthly meeting for review and recommendations as identified and needed. See page 16 for 514.	9-16-11
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		

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F 514	Continued From page 15 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy review, and interview, the facility failed to have accurate medical records for two (#2, #18) of twenty-one residents reviewed. The findings included: Resident #2 was admitted to the facility on June 20, 2007, and readmitted on August 17, 2007, with diagnosis including Cerebrovascular Accident with Hemiparesis, Acute Respiratory Failure, and History of Seizure Disorder. Review of the pharmacy recommendation dated June 3, 2011, revealed "...resident followed by hospice has monthly Dilantin ordered...indicate if you wish to continue monthly-or-schedule with other lab work ordered q6M (every six months)..." Further review revealed the physician agreed with the recommendation with the notation "q 6 months" dated June 21, 2011. Review of the physician phone order dated June 21, 2011, revealed "clarification order-it is recommended for dilantin order to be drawn q 6 (hour) (hospice resident)".	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F514 It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. August 9, 2011 a clarification order was written to correct the July 2011 Recapitulation Physician Order to reflect the change for Dilantin Level every six months for Resident #2. The Medical Records Clerk reviewed the clarification order to ensure the August recap order was correct. The DON, ADON, Medical Records Clerk and Nursing Supervisors will audit 10% of Recapitulation of Physician orders coded "OL"(orders for lab) to ensure accuracy of medical records monthly for three months or until no further discrepancies are noted. August 9, 2011the Executive Director, Medical Records Clerk and District Director of Clinical Operations reviewed the policy and procedures for Closing a Medical Record PRO 13105. Effective immediately the Medical Records Clerk will follow procedures as outlined in the Closing a Medical Record. The Director of Clinical Operations will review 3 discharged charts monthly for three months or until no further	9-16-11

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F 514	Continued From page 16 Review of the July 2011 Recapitulation Physician Order signed by a facility nurse on June 29, 2011, and signed by the physician on July 11, 2011, revealed "Dilantin level monthly." Interview with the Director of Nursing on August 9, 2011, at 2:25 p.m. at the north nursing station, confirmed the June 21, 2011, physician agreement with the pharmacy recommendation did not match the June 21, 2011, phone order. Continued interview confirmed the July 2011 Recapitulation Physician Order did not reflect the change from monthly to every six month dilantin level. Resident #18 was admitted to the facility on May 19, 2011, with diagnosis including New Onset Seizures, Acute Cerebrovascular Accident, Cirrhosis, Jaundice, and Alcohol Abuse. Medical record review revealed the resident was discharged to home on June 10, 2011, with home health. Medical record review revealed the Discharge Summary was not completed; and not signed by the physician. Review of the facility policy "Closing a Medical Record" revealed "...resident's medical record is completed and closed within 30 days after discharge...17. Obtain the signatures of both the Administrator and Medical Director on the (discharge) summary...19. Review the discharge summary completed by the attending physician for the discharge diagnoses..." Interview with the District Director of Clinical	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F514 continued discrepancies are noted. The DDCO will report her findings to the Executive Director. The Executive Director will report audit findings for Closing a Medical Record and the DON will report on audit for lab orders along with any corrective actions to the facility Performance Improvement Committee (Executive Director, DNS, Plant Operations Mgr, Dietary Manager, ADON, Staff Development Coordinator, Activity Director, Social Service Director, Housekeeping /Laundry supervisor, and Medical Director) at its monthly meeting for three months, or until no further discrepancies are noted, for review and recommendations as identified and needed.	9-16-11

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F 514	Continued From page 17 Operation on August 9, 2011, at 9:50 a.m., in the conference room, confirmed the physician failed to complete and failed to sign the discharge summary.	F 514		